North Carolina Department of Health and Human Services

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Leza Wainwright, Director

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
Craigan L. Gray, MD, MBA, JD, Director

March 1, 2010

MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray
Leza Wainwright

SUBJECT: Implementation Update #70

- Suspension of Mandatory Cost Reporting
- CABHA Update
- Impact of Merger & Acquisitions on Enrollment/Accreditation/Endorsement
- PSR Service Notes
- Day Treatment Endorsement Checksheet
- MOA for Child & Adolescent Day Treatment
- New CTCM Form for MR/DD Submissions to VO
- Policy Changes for Case Management
- Extension for Provisionally Licensed Billing
- DMA Program Integrity Contract with PCG
- Payment Error Rate Measurement in NC
- Medicaid Provider Payment Suspension
- Census 2010

Suspension of Mandatory Cost Reporting for Rate Adjustments

The Department of Health and Human Services (DHHS) recognizes that the unprecedented Medicaid budget reductions in state fiscal year 2010 have impacted both providers and recipients. In order to remove some of the administrative burden and cost to providers, the Division of Medical Assistance and the DHHS Controller's Office are suspending the requirement for mandatory cost reporting of Medicaid costs for cost reports due after December 31, 2009 for the following provider groups:

- CAP MR/DD Providers
- Substance Abuse (SA) & Personal Care Service (PCS) Adult Care Home Providers
- PCS – Community Based Providers
- Enhanced Mental Health Providers
- Residential Treatment Providers

The Division of Medical Assistance (DMA) is not planning rate adjustments based on cost during this period of suspension. Should it become necessary to determine reasonable costs during the suspension period, DMA will utilize its existing cost report database and cost trending factors.

Any outstanding cost reports from previous cost report periods are due and must be filed. Outstanding issues resulting from a previously filed cost report must also be resolved.

This suspension shall remain in effect until rescinded by the Secretary of DHHS. If you have specific questions please contact the following individuals:

- CAP MR/DD Providers and Residential Treatment Providers – Paul Cole at 919-855-3685 or Mishawn Davis at 919-647-8179.
- SA & PCS - Adult Care Home Providers – Paul Cole at 919-855-3685 or Elizabeth Grady at 919-855-4207.
- PCS - Community Based Providers – Roxanne Krotoszynski at 919-855-4216.
- Enhanced Mental Health Providers – Paul Cole at 919-855-3685 or Christal Kelly at 919-647-8178. The suspension also includes those CAP MR/DD and Mental Health Residential Treatment providers who also provide enhanced mental health services.

For all cost reports due prior to December 31, 2009, the Division of Medical Assistance's policies and rules for timely submission will continue to be in effect.

Providers should continue to record their accounting transactions in accordance with the approved chart of accounts and cost allocation principles to ensure that when the suspension is rescinded, providers will be able to complete and file cost reports within the prescribed timeframe.

We recognize the financial hardships of our provider network and hope that this reduction of administrative cost will assist providers as we work our way through these difficult economic times.

Critical Access Behavioral Health Agency Update

CMS Approval of Critical Access Behavioral Health Agencies in NC Medicaid State Plan
The Centers for Medicare and Medicaid Services (CMS) have approved a State Plan Amendment (SPA) that will allow only Critical Access Behavioral Health Agencies (CABHA) to provide Intensive In-Home Services (IIH), Community Support Team (CST), and Child and Adolescent Day Treatment services effective July 1, 2010.

Updated Letter of Attestation
An updated Letter of Attestation for CABHA certification has been placed on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) webpage: http://www.ncdhhs.gov/mhddsas/cabha/index.htm. The letter has been revised to include the following additional information:

- Agency site addresses and endorsing local management entities (LME) for all Medicaid provider numbers.
- Clarification regarding the inclusion of the service continuum in the written explanation of the management and clinical structure of the organization.
- Identify the LME(s) where the continuum of services for the certified CABHA site are located. Services within a continuum are required to be within a 35 mile radius of the site where the core services are provided as referenced in the Centers for Medicare and Medicaid 42 CFR Ch. IV (10-1-09 Edition) § 413.65.
- Identification of the two additional services to be considered as part of the continuum if more than two services are provided by the agency.

Please note that any Letters of Attestation postmarked after the date of this Implementation Update must utilize the updated letter. In addition, due to the overwhelming interest in CABHA it is no longer necessary for providers to submit Letters of Intent; in order to initiate the certification process, providers must submit Letters of Attestation and supporting documentation.

Continuum of Care
Critical Access Behavioral Health Care Agencies are required to operate and describe a continuum of care for a selected age/disability group. This description should include the core services and at least two enhanced services. The description should describe the proposed continuum of care indicating the required competencies and professional qualifications for each level of care (the core plus enhanced services) for the selected population. To be specific each CABHA will describe the following services as a continuum: comprehensive assessment, outpatient treatment, medication management, and two enhanced services for an age/disability group.

The continuum describes treatments as a series of levels of care. The levels are expressed in graduations of intensity within and between levels of care. Levels of care represent intensities of services along the continuum, each of which may be provided in a variety of program types. The continuum should inform the transition of individuals with substance use

and/or mental health problems away from fixed program-driven treatment to assessment-based, clinically driven, person centered treatment. A typical assignment of intensity levels begins with the least intensive professional service available to the individual and might be exemplified as early intervention services followed by outpatient services, then more intensive outpatient services, followed by residential levels of care and culminating with inpatient levels of care. The continuum of care must be flexible enough in its application to allow for stepping up or down in intensities of services based on the consumer's process of recovery.

Treatment should be tailored to the needs of the individual and guided by an individualized person centered plan that is developed in consultation with the consumer. The plan should be written to facilitate measurement of recovery. The length of service at a particular level of care in a continuum should be linked directly to the consumer's response to treatment. The resolution of problems at any level of care determines when the consumer can be treated safely at a different level of care or discharged from treatment.

The levels of care in a continuum are designed to treat the individual's level of clinical severity and to help the individual achieve permanent change in his or her mental functioning and/or alcohol and drug using behavior. Assessment considerations for determining appropriate levels of care should include assessments of risk to health and safety, other chronic health conditions and/or cognitive conditions. The assessment would then be matched with necessary medications and that would be matched to appropriate outpatient strategies or enhanced service levels of care. It is important to note that in assessing co-occurring disorders, a mental health or substance related disorder should be considered secondary only if it shows improvement as a result of stabilization in the other disorder. Effective continuums also include relapse services and continued care levels.

CABHA Medical Director Exception Process

Implementation Update #68 defines other categories of physicians (besides psychiatrists) who could be approved as Medical Directors for CABHAs. These other physicians require specific approval from the Secretary of the Department of Health and Human Services; this update details the exception process that needs to be followed. The other categories include those physicians who are board-certified or board-eligible in:

- general family practice, or
- internal medicine, or
- pediatrics; and
- with two or more years of direct service experience diagnosing, treating, and evaluating the effectiveness of treatment of the population to be served by the CABHA.
- Consideration will also be given to physicians with these credentials who have received additional training or certification related to treating the populations to be served and those who have prior experience as a medical director for a mental health and/or substance abuse provider organization.

Agencies wishing to request an exception under this policy should submit the following with their attestation packet regarding their particular physician:

- Curriculum vitae
- Description of the scope of work and population served in the CABHA
- Other information which may include: additional educational experience in the field; academic work (papers, presentations, publications, etc.)
- Statement of supervisory consultation/ongoing mentoring

If sufficient information is provided to support the exception, the request will be submitted to a committee of DHHS representatives. This committee will then review the information and make a recommendation to the Secretary (or his designee) regarding whether to approve/not approve the exception to the medical director requirement. The decision regarding the exception will be completed as part of the desk review process.

In accordance with N.C.G.S. §150B-23(f), provider's may appeal the decision to the Office of Administrative Hearings within sixty (60) days of the date of notification of the decision. The procedure to file an appeal and the required forms may be obtained from http://www.ncoah.com/hearings/.

CABHA Transition for IIH, CST, and Day Treatment

Provider agencies that are interested in achieving CABHA status by July 1, 2010 in order to provide IIH, CST, and/or Day Treatment services must submit a Letter of Attestation to Contact.dmh.lme@dhhs.nc.gov prior to April 1, 2010. The submission of the attestation letter before this date will ensure that the required reviews/certification will be completed within the remaining three months. In addition, this schedule will allow LMEs to assist in the transition of consumers from those agencies who are not certified as CABHA prior to the July 1, 2010 deadline. Providers of these three services that do not submit letters of attestation for CABHA certification by April 1, 2010 must assist the LME in planning and implementing a transition plan for consumers served by the agency.

The April 1 date does not impact providers who are applying for CABHA certification and do not provide IIH, CST, or Day Treatment.

CABHA Certification after July 1, 2010
We have received questions regarding how a new provider could become a Critical Access Behavioral Health Agency (CABHA), especially after July 1, 2010 when endorsement for Community Support Team, Intensive In-Home and Day Treatment will be limited to CABHAs. The steps for becoming a CABHA under those circumstances are outlined below:

1. Create a company that provides a MH/ SA service(s) not subject to CABHA requirements.
2. Become endorsed by the LME, if required, to deliver that service(s).
3. Achieve three year national accreditation for that service(s).
4. Hire, if not already employed or contracted, the physician (half-time or full-time), clinical director, and quality improvement/training director. Individuals must be employed for 60 days prior to submission of an attestation letter for CABHA application.
5. Submit a letter of attestation for CABHA application, indicating if endorsement is being sought for Community Support Team, Day Treatment or Intensive In-Home to create the necessary continuum.
6. Assuming letter of attestation passes the desk review, LMEs will perform endorsement review for other services requested as part of LME verification of the CABHA application.
7. Assuming LME review and endorsement meet requirements, complete CABHA interview process.
8. Enroll the provider as a CABHA if the provider meets all criteria.
9. Apply for endorsement for case management and, if desired, peer support.

CABHA Medicaid Provider Enrollment
Providers who have achieved certification as a Critical Access Behavioral Health Agency will need to complete a Medicaid Provider Enrollment Application to obtain a Medicaid provider billing number. (http://www.nctracks.nc.gov/provider/providerEnrollment/) The new billing number will be used by the CABHA in order to bill for services rendered by both the direct-enrolled individuals and by group service providers certified under the CABHA. Therefore, the CAHBA number will be the "billing number" for reimbursement for the services required to be provided by a CABHA. These services include the core services (Comprehensive Clinical Assessment, Medication Management, and Outpatient Therapy services); as well as, Community Support Team, Intensive In-Home and Day Treatment and/or others designated to be provided by the CABHA. After July 1, Community Support Team, Intensive In-Home and Day Treatment will be reimbursed only to the CABHA billing provider number. Upon approval by CMS, Peer Support and Mental Health/Substance Abuse Targeted Case Management may be provided only by the CABHA and reimbursed only through the CABHA billing number. These services will need site specific endorsement and provider numbers that will be the "attending provider number" **on the claim** for reimbursement.

Additional information about Medicaid enrollment of CABHA providers will be provided within the next several weeks.

Policy Guidance on the Notification and Impact of Mergers and Acquisitions on Provider Medicaid Enrollment, National Accreditation, and Endorsement
When there is a reorganization, merger, or change of ownership, the provider has the responsibility to inform DMA, DMH/DD/SAS, the LME, and the provider's national accrediting body of such change.

Policy for Notification of Change in Ownership/Merger/Acquisition for Provider Organizations and Impact on Medicaid Enrollment Status
Providers are responsible for notifying CSC, N.C. Medicaid's provider enrollment agent, when information related to their business or practice changes.

Change of ownership/merger/acquisition is constituted by any of the following:

- An exchange of monies or an asset purchase, both of which result in the assignment of a new tax identification number; a stock purchase, which may not result in the assignment of a new tax identification number.
- A change in a shareholder's/partner's percentage of interest in ownership.
- A transfer of title and property to another party; or a merger of the provider corporation into another corporation or the consolidation of two or more corporations resulting in the creation of a new corporation.

If there is a change in the organization, CSC must receive notification within 30 days of the change.

1. **Submit an online Provider Enrollment Application for the organization**
   http://www.nctracks.nc.gov/provider/providerEnrollment/

2. **Use company letterhead to provide the following:**
   Liability Statement - Any change of ownership/merger/acquisition shall not be approved unless and until the new owner/entity agrees in writing to assume all liability, including, but not limited to, cost report settlements, health care assessment settlements, or recoupment actions, that have arisen or that may arise in connection with claims billed by provider. This will allow the new owner to retain the previous owner's Medicaid provider number(s) if desired.

   Site Change - Has the organization added or deleted any sites, or have any of the sites moved? List the name of each affected site including the address and telephone number, the services provided at the site, and the effective date of the change.

   Services Change - Has the organization added or deleted services since its last endorsement? Has the organization added or deleted services since its last accreditation survey? Please tell us about the service changes and effective dates of the changes.

   Merger - Has the organization merged two or more organizations? Please submit the following:
   - Names of the organizations merged
   - Medicaid provider numbers of the organizations merged
   - The effective date of the merger
   - Any other detailed information regarding the merger

   Acquisition - Has the organization acquired one or more organizations? Please include the following in the letter:
   - Names of the organizations acquired
   - The effective date of the acquisition
   - Any other detailed information regarding the acquisition

   Organization Closure - Is the entire organization closing, or an accredited program of the organization closing? Identify the name and address of the organization and the effective date of closure.

Submit the updates within 30 days of the change to:
NC Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020
Or Fax to 1-866-844-1382

AND to:
DMH/DD/SAS
3012 Mail Service Center
Raleigh, NC 27699-3012
Or Fax to 919-508-0968

AND to:
Provider's Endorsing Agency (if applicable)

Policies for Notification of Change in Ownership/Mergers/Acquisitions and Impact on Accreditation Status
Each accrediting body requires that the provider notifies them of any change in management or organizational structure, including reorganization, mergers, acquisitions, and closures. Accreditation is awarded to a specific provider and is typically not transferred from the previous agency to the acquiring or absorbing agency. The determination of whether a new survey is required is made on a case-by-case basis depending on the facts and circumstances of the merger, including, but not limited to

- the information presented to the accrediting body on how the two entities are going to incorporate;
- whether a new 501(c)(3) number is obtained;
- which entity is taking over the management of the new entity;
- the expansion of services to other sites and locations; and
- how close the provider is to the renewal of their accreditation, etc.

An on-site supplemental survey is almost always required when an organization changes its leadership or ownership or engages in a merger, consolidation, joint venture, or acquisition or when the organization wants to add a new program or

service that is not currently accredited, including cases where an accredited provider merges with another provider that is not accredited by the same accrediting body.

In most cases, an organization loses its accreditation when the organization goes out of business or discontinues providing the services for which it was accredited. An organization that loses its accreditation may, in most instances, reapply to re-establish accreditation; however, a provider that has lost its accreditation should no longer represent itself as an accredited agency and should take reasonable steps to notify the public of the same.

Changes in the organizational infrastructure of a provider agency due to mergers or acquisitions may impact the provider's accreditation status. Providers should refer to their accrediting body's policy regarding this matter for more specific details.

Policy for Notification of Change in Ownership/Mergers/ Acquisitions and Impact on Endorsement Status
When two or more corporations merge resulting in the creation of a new corporation (new organization name, new tax ID number) endorsement of the new corporation will be required.

When a provider is endorsed and there is a change of ownership affecting the provider organization, the provider must notify the endorsing agency, DMH/DD/SAS, and DMA of the changes via a letter on company letterhead (as noted above in #2). The following circumstances will require notification:

- A change in a shareholder's/partner's percentage of interest in ownership.
- A transfer of title or property to another agency that is already endorsed.
- A merger of another provider corporation into another corporation that is already endorsed.
- An exchange of monies or an asset purchase, both of which result in the assignment of a new tax identification number, but the service and or site is already endorsed.
- A stock purchase, which may not result in the assignment of a new tax identification number.

When a provider is endorsed to provide services at a specific site and moves to a different site location within the same LME catchment area (providing the same services), the new site does not need to be endorsed. However, if the move is to a new LME catchment area and that site location has not been endorsed, the new site must be endorsed for that service.

Psychosocial Rehabilitation Service Notes
DMA and DMH/DD/SAS are pleased to announce that Psychosocial Rehabilitation (PSR) services may be documented in the service record on a weekly basis, effective March 1, 2010. CMS has granted approval for PSR services to be documented in a full service note, but on a weekly basis instead of per date of service. This means that all the guidance contained in this Implementation Update supersedes the section on page 8-8, as well as on page 10-11, in the *DMH/DD/SAS Records Management and Documentation Manual (RM&DM)* that requires a service note per date of service for PSR.

With this new allowance, PSR providers must be aware that there will be some additional requirements that must be met in order to properly document progress on a less frequent basis. The *RM&DM* already describes how services are to be documented when the frequency requirements are less than per date of service. However, to assist PSR providers in the move from a daily note to a weekly note, "PSR Guidance for Service Notes" is attached to this Implementation Update to delineate the basic requirements needed. Providers are strongly encouraged to use this attachment to ensure that all the proper documentation requirements are met.

Child and Adolescent Day Treatment Endorsement Checksheet and Instructions
The endorsement checksheet and instructions for the revised Child and Adolescent Day Treatment service definitions are attached and will be posted to the Endorsement Page of the DMH/DD/SAS website at: http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm. These items are to be used for any endorsement of Day Treatment that occurs on or following April 1, 2010. The checksheet and instructions reflect revisions to the service definition as well as the proposed changes to the Endorsement Policy. As with all service definition changes, currently endorsed providers of this service will be expected to be in compliance with the new service definition on April 1, 2010.

Memorandum of Agreement for Child and Adolescent Day Treatment Services
Medicaid and state mental health funds do not pay for educational services for eligible children. However, we recognize that effective models of practice require intentional interagency coordination to meet both the therapeutic treatment as well as the educational needs of each child or youth receiving day treatment services. Therefore, in accordance with the requirements outlined in the Child and Adolescent Day Treatment Services definition posted with an effective date of April 1, 2010 in the DMA Clinical Coverage Policy 8A (http://www.ncdhhs.gov/dma/mp/8A.pdf), a memorandum of agreement (MOA) must be established in order for this service to exist.

The MOA must be established between the provider, local educational agency (LEA), and the LME. The MOA is negotiated, developed, and signed locally. In order for endorsement of this service to be completed, a MOA must be in place. Participation as a party to the MOA is a local option for each entity and is locally determined.

Attached is a document entitled, "Elements to Consider Including in the Memorandum of Agreement for the Implementation of Child and Adolescent Day Treatment Services." This document contains a list of sections and content that may be considered as local MOAs for day treatment services are developed. Items to be considered include:

- Brief description of the day treatment service
- Basic information regarding the MOA
  - Date effective
  - Parties involved
  - Purpose
  - Student criteria as eligible recipient for day treatment services
- Obligations of each party signing the agreement
  - Day treatment provider
  - Local education agency or private school, as appropriate
  - Local management entity
- How modifications will be made
- Maintaining confidentiality
- Conflict resolution
- How the agreement may be terminated
- The term of the agreement
- The signing authorities for each party

Effective implementation of day treatment services must be coordinated with each child's general educational and special educational services in an LEA. Coordination among the provider, the school and the LME must occur with a concerted focus on achieving positive child outcomes through day treatment. When implemented well, the following occur: a reduction in child symptoms, smooth transitions, positive engagement with peers and participation in the 'regular' school day as day treatment goals and outcomes have been achieved or day treatment is no longer clinically appropriate.

New CAP/Targeted Case Management (CTCM) Form for MR/DD Submissions to ValueOptions

A new CAP/Targeted Case Management (CTCM) request for authorization form has been approved and MUST be used in conjunction with the new person centered plan (PCP) for MR/DD plans of care, Continued Need Reviews (CNR) and non-waiver DD Case Management. ValueOptions has posted the new CTCM on their website for immediate use as of March 1, 2010. Due to changes in the PCP, the additional information required on the new CTCM, such as diagnoses and medications, is essential to the review process. The new CTCM form can be accessed at: http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

If a CNR was submitted prior to March 1, it does not need to be re-submitted to ValueOptions.

Policy Changes for Case Management Services

This article is being republished to correct the instruction to providers to bill with the new procedure code T1017SC if additional hours (up to six hours/24 units) are needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation. The correct code to bill for these additional hours **is the procedure code currently submitted for case management services with an informational modifier SC appended to the code.**

Beginning **March 1, 2010,** DMA will change the policies as described below for the following programs: CAP/DA, CAP/Choice, CAP/C, CAP/MR-DD, Targeted Case Management for Persons with Developmental Disabilities, and Early Intervention.

- The maximum number of units for case management services will be limited to no more than three hours (12 units) per calendar month for each recipient. See Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Medicaid for Children below. Providers should continue to use the current program case management billing codes.
- No more than six additional hours (24 units) may be available if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation.
  - It is not necessary to bill all of the additional units on the same claim. These additional units can be used cumulatively within a rolling 365 day period.
  - Any billing for assessments and crises case management above this annual limit will not be paid for adults 21 years of age and older. For children under 21 years of age, requests will be reviewed under EPSDT. (See EPSDT below.)

- These six hours (24 units) are in addition to the three hours per calendar month.
- When billing for these additional six hours/24 units, **all programs must use the procedure code currently submitted for case management services and append an informational modifier SC to that detail.** For example:
  - CAP/C and CAP/DA would bill with T1016SC.
  - CAP/MR-DD, Early Intervention would continue to bill with T1017HI and append a second modifier of SC.
  - CAP/Choice would bill with T2041SC.

Early Intervention (EI)
Effective March 1, 2010, any recipient receiving more than three hours (12 units) per calendar month will have his/her hours reduced to the limit of three hour (12 units). This will not affect the entitlement that is applied under the Early Intervention Program for service coordination as listed in the Individualized Family Service Plan.

Providers may request additional units (additional annual and monthly) by following the EPSDT requirements as outlined on http://www.ncdhhs.gov/dma/epsdt/. If the request exceeds the policy limits described above, the request will be reviewed under the EPSDT criteria. If the request meets all of the EPSDT criteria and the requested amount is necessary to meet the child's needs, the request will be approved. If the request does not meet all of the EPSDT criteria or the request exceeds what is necessary to meet the child's needs, the request will not be approved at the level requested.

Developmental Disability (DD) Case Management (Waiver and Non-waiver)
The following procedures apply to providers of DD case management (waiver and non-waiver):

- Current authorizations with effective dates prior to March 1, 2010, will continue as authorized until the next annual continued need review (CNR). The three hour/12 unit limit policy will be applied at the next annual review.
- Effective March 1, 2010, prior authorization of case management services for adults on the Supports and Comprehensive waivers will not be required. These adults will be eligible for up to three hours/12 units monthly as well as the additional 24 units for assessment, planning, and crisis management annually. Non-waiver adults will continue to require prior authorization and may be authorized for up to three hours/12 units per month and no more than six additional hours/24 units if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation. Should a case manager submit a request for a non-waiver recipient that exceeds the policy limits, the case will be reviewed to determine how many hours/units are necessary to meet the recipient's needs (one, two, or three hours per calendar month and/or six or less additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days).
- Effective March 1, 2010, prior authorization of case management services for children on the Supports and Comprehensive waivers will not be required unless the request exceeds the three hour/12 unit monthly limit or the 24 unit limit for assessment, planning and crisis situations.. Non-waiver children will continue to require prior authorization.
- Waiver and non-waiver children must be evaluated under the EPSDT requirements prior to reducing their current service level at their next annual review and for authorization requests that exceed the three hour/12 unit limit or the 24-unit limits for assessment, planning, and crisis management. See the section below regarding EPSDT.
- State funded case management authorization limits are based on each LME's benefit plan.

The case manager may request the additional six hours/24 units (T1017SC) for these current authorizations even if the current monthly authorization is in excess of the three hour/12 units per month. These requests will be reviewed under the EPSDT criteria.

All Other Programs (CAP/DA, CAP/Choice, CAP/C)

- Case management services for all other affected programs will continue as currently approved until the next CNR, or reauthorization is submitted. At that time, the case management unit limits will be applied as specified in the first paragraph of this article.
- All case management units must be documented on the cost summary. It is **important** to note that the conditions set forth in the CAP waiver concerning the recipient's budget and continued participation in the waiver apply. That is, the cost of the recipient's care, including case management services, must not exceed the waiver cost limits specified in the CAP waiver.
- Children will be evaluated under EPSDT requirements prior to taking any adverse action. See the section below regarding EPSDT.

Documentation for case management billable units is required per respective clinical coverage policies. Lack of supportive documentation for billed units will be referred to Program Integrity for possible recoupment.

EPSDT
While the new limit on case management services has been reduced to no more than three hours (12 units) per calendar month and no more than six additional hours (24 units) if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation, these limits may not apply to children under 21 years of age. Federal law, 42 U.S.C. §1396d(r)(5), requires the State Medicaid agency to provide to Medicaid recipients under 21 years of age "necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the [Social Security] Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] Plan." For more information about EPSDT and provider documentation requirements for EPSDT requests, please visit http://www.ncdhhs.gov/dma/epsdt/.

Recipient Due Process

Children
As indicated above, all requests for recipients under the age of 21 that exceed policy limits will be reviewed against the EPSDT criteria prior to taking adverse action, and the recipient or his/her legal guardian will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), as well as state the EPSDT criteria not met, and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

Adults
If the decision authorizes case management services to the policy limit (three hours per calendar month and/or six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days), the recipient or his/her legal guardian will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction to the policy limit, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10) as well as DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and that pursuant to 42 CFR §431.210 and §431.220(b), the recipient is not entitled to appeal this decision.

Should less than three hours (12 units) per calendar month and/or less than six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days be authorized, the recipient or his/her legal guardian will receive a written notice explaining the decision, and that he/she is entitled to appeal the decision to authorize less than the policy limit. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), as well as DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

Recipient Notice Regarding Reductions in Case Management Services
A notice was sent at the end of January to recipients regarding these changes in case management. See the DMA website (http://www.ncdhhs.gov/dma/pub/consumerlibrary.htm) for a copy of the notice.

Extension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through the Local Management Entity
The deadline for coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid and state funds and billed through the Local Management Entity (LME) **has been extended to June 30, 2011.** DMA and DMH/DD/SAS will continue to pay for services delivered by the provisionally licensed individuals listed above when billed through LMEs under HCPCS procedure codes H0001, H0004, and H0005 until that date.

As outlined in Implementation Update # 32 (on the DMH/DD/SAS Enhanced Services Implementation Updates web page), the LME may choose to provide this billing service on behalf of the provisionally licensed professional. If the provisionally licensed professional is employed by an agency, the agency must develop a contract directly with the LME to do this billing for them. If provisionally licensed professionals work independently, they should contact their licensure board prior to developing a contract with the LME to ensure compliance with each profession's scope of practice. Please note that the LME may charge 35¢ per claim to perform this billing function.

In addition to providing outpatient behavioral health services billed through an LME, there are various other means for provisionally licensed professionals to obtain the clinical experience required by their licensing boards. These include

- providing outpatient services working with a physician using Medicaid's "incident to" policy (see the March 2009 Medicaid Bulletin);
- providing enhanced behavioral health (Community Intervention) services as the qualified professional (QP) in order to receive family- and community-based clinical experience; and
- serving as the licensed professional in the Intensive In-Home service.

DHHS-DMA Program Integrity Contract with Public Consulting Group (PCG)

Medicaid services are provided to recipients in all 100 North Carolina counties. In accordance with CFR 42 Part 455, which sets forth requirements for a State fraud detection and investigation program, the DMA's Program Integrity Section investigates Medicaid providers when clinically suspect behaviors or administrative billing patterns indicate potentially abusive or fraudulent activity.

The review of providers of Community Behavioral Health services has presented unique challenges. These challenges and the related volume of cases have resulted in a backlog that requires immediate attention. Program Integrity is committed to initiating these reviews and safeguarding against unnecessary or inappropriate use of Medicaid services and against excess payments.

In accordance with 10 NCAC 22F.0202, a preliminary investigation shall be conducted on all complaints received or aberrant practices detected, until it is determined that there are sufficient findings to warrant a full investigation; or there is sufficient evidence to warrant referring the case for civil and/or criminal fraud action; or there is insufficient evidence to support the allegation(s) and the case may be closed.

Effective January 28, 2010 Public Consulting Group (PCG), will assist the NC Division of Medical Assistance's Program Integrity, Behavioral Health Review Section in eliminating a backlog of cases and prospectively maintaining a steady state of case reviews, preventing a future backlog of cases from accumulating. For assigned cases, PCG will absorb the full scale of operations, beginning with the receipt of a case file, conducting the clinical review, establishing a statistically valid claim review sample for review, and extrapolating these findings to calculate the recoupment.

PCG will initiate contact with the provider, inform the provider of the post payment review process requirements, and work closely with the provider and DMA. PCG will advise the provider where and how to submit records for the review, and will address provider questions regarding the post payment review process. If the provider is out of compliance, a recoupment letter shall be forwarded to the provider in the amount of the overpayment. The provider will have reconsideration and appeal rights should the agency not agree with the findings of the review. Those instructions will be sent out with the recoupment letter.

If the preliminary investigation supports the conclusion of possible fraud the case shall be referred to the appropriate law enforcement agency for a full investigation.

For more information contact the Behavioral Health Review Section at (919) 647-8000.

Payment Error Rate Measurement in North Carolina

In compliance with the Improper Payments Information Act of 2002, the Centers for Medicare and Medicaid Services implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). North Carolina is one of 17 states required to participate in PERM reviews of Medicaid Fee-For-Service and Medicaid Managed Care claims paid in Federal Fiscal Year 2010 (October 1, 2009-September 30, 2010). The SCHIP review for FY2010 is on hold until a final ruling is made to include or exclude the measurement from this PERM cycle.

CMS is using two national contractors to measure improper payments. Livanta is the Statistical Contractor (SC). The review contract (RC) has been awarded to A+ Government Solutions. A+ will request medical records and perform data processing reviews for the FY 2010 PERM cycle. A+ has subcontracted with Health Data Insights to perform the medical reviews, and collect policies necessary for medical review. The review contractor will notify the provider by letter if one of their claims is selected for PERM review. Providers are required to furnish the records requested by the review contractor, within the designated timeframe.

Providers will be notified of medical records request by letter from the review contractor. Providers are urged to respond to these requests promptly with timely submission of the requested documentation. Failure to submit records within the designated time frame will result in an error for the state.

The PERM team within Program Integrity (P.I.) will review all claim errors declared by the RC in an effort to dispute the error and reverse the finding, thereby eliminating the error from the state's final error rate. The P.I. team may contact the

provider for further information. All indefensible errors will be recouped from the provider according to state and federal regulations.

Providers are reminded of the requirement in Section 1902(a)(27) of the Social Security Act and Federal Regulation 42 CFR Part 431.107 to retain any records necessary to disclose the extent of services provided to individuals and, upon request, furnish information regarding any payments claimed by the provider rendering services.

Medicaid Provider Payment Suspension

DMA shall immediately suspend payment to all NC Medicaid providers that currently have outstanding (i.e. thirty days or more past due) balances owed as a result of DMA actions to recoup assessments, overpayments or improper payments until such outstanding balances are either paid in full or the provider enters into an approved payment plan, in accordance with N.C. Session Law 2009-451, Section 10.73A.(a) (b) (c), which states:

SECTION 10.73A.(a) The Department of Health and Human Services may suspend payment to any North Carolina Medicaid provider against whom the Division of Medical Assistance has instituted a recoupment action, termination of the NC Medicaid Administrative Participation Agreement, or referral to the Medicaid Fraud Investigations Unit of the North Carolina Attorney General's Office. The suspension of payment shall be in the amount under review and shall continue during the pendency of any appeal filed at the Department, the Office of Administrative Hearings, or State or federal courts. If the provider appeals the final agency decision and the decision is in favor of the provider, the Department shall reimburse the provider for payments for all valid claims suspended during the period of appeal.

SECTION 10.73A.(b) Entering into a Medicaid Administrative Participation Agreement with the Department does not give rise to any property or liberty right in continued participation as a provider in the North Carolina Medicaid program.

SECTION 10.73A.(c) The Department shall not make any payment to a provider unless and until all outstanding Medicaid recoupments, assessments, or overpayments have been repaid in full to the Department, together with any applicable penalty and interest charges, or unless and until the provider has entered into an approved payment plan.

For additional information on a repayment plan, please contact DMA Budget Management at (919) 855-4140.

Census 2010

The U.S. Census 2010 will begin in a few weeks. It is important that all voices be heard and that every individual is encouraged to participate. As you communicate with consumers, families and staff about Census 2010 you may wish to reference the following facts:

It's easy - The census form only has ten questions and should only take a short time to complete. While some people may be overwhelmed and have questions, assistance is available through Question and Assistance Centers (QAC). The U.S. Census has also published a toolkit, "Supporting the 2010 Census: Toolkit for Reaching People with Disabilities" at the following link: http://2010.census.gov/partners/pdf/toolkit_Disability_Overview.pdf

It's your responsibility and right - The census will help to determine changes in population throughout the country; it plays a part in deciding how billions of dollars per year are spent on important issues such as funding for people with disabilities.

It's safe and confidential - Some people may be reluctant to share personal information on the census form or with census workers. It is important to point out that information on the census form is kept confidential and census workers are sworn for life to keep information confidential. Some people may also be apprehensive about strangers coming to talk to them. Remind everyone that census workers carry identification to protect confidentiality.

Thank you for spreading the word. We all need to participate in the census and to ensure that the voices of all North Carolinians are heard. Please encourage and support everyone's participation in the process. We have also attached a sample fact sheet that you may use in your own written and oral communications to consumers and family members.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

cc: Secretary Lanier M. Cansler
Allen Feezor
Michael Watson
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Christina Carter
Sharnese Ransome
Jennifer Hoffmann
Shawn Parker
Melanie Bush
John Dervin
Kari Barsness
Lee Dixo